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F 000	INITIAL COMMENTS An unannounced bi-annual survey and complaint visit was conducted at this facility from November 9, 2011 through November 22, 2011. The deficiencies contained in this report are based on observation, interviews, and review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was one hundred and sixty-nine (169). The survey sample totaled fifty-two (52) residents and one (1) sub-sampled resident for observation.	F 000	The filing of this plan of correction does not constitute any admission as to any of the violations set forth in the statement of deficiencies. This plan of correction is being filed as evidence of the facility's continued compliance with all applicable law. **The facility has achieved substantial compliance with all requirements as of the completion date 01/31/12 for all noted deficiencies.** Therefore, the facility requests that this plan of correction serve as its allegation of substantial compliance with all requirements.	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in	F 157	F157 1. The attending physician was notified of R161's edema in right lower extremity. 2. Any resident with a change in condition has the potential to be affected by this practice and is reviewed daily at the routine morning meeting. 3. The policy and procedure "Guidelines for Reporting Change in Resident Condition or Status," was reviewed and revised by the Medical Director and Director of Nursing. SBAR implementation will be started January 2012 to ensure appropriate communication to the physician.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 12/21/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview it was determined that the facility failed to consult the physician regarding a significant change for one (R161) out of 52 sampled residents who acquired edema (swelling) to a casted leg. Findings include: R161 was admitted to the facility with diagnoses that included hypertension, polyneuropathy diabetic, old history of polio, amputation right great toe, cerebral accident, and peripheral vascular disease. On 10/11/11 R161 acquired a fracture of the right tibia and had a cast applied. On 10/18/11 the nurses notes documented that R161 had 2+ swollen (edema) to both of his feet. On 10/22/11 a nurse documented on the 7-3 shift R161 had right lower extremity +2 edema. The 3-11 nurse documented that R161 had +3 edema in the right leg. On 10/23/11 at 3:00 PM the nurse documented that R161 had +3 edema with positive pedal pulses to his right leg. There was no documentation indicating that the physician was notified of the increased edema for R161.	F 157	Education was provided to license nursing staff on the revised "Guidelines for Reporting Change in Resident Condition or Status" and on SBAR process. 4. Resident's identified with a change in condition is reviewed at the daily morning meeting to ensure the attending physician is notified of changes timely. Results are aggregated and reported at the monthly QA/QI Committee Meeting.	

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F 157	Continued From page 2 On 10/24/11 the 7-3 nurse documented skin break down from cast on R161's right lower extremity. The orthopedic physician was called and the cast was cut to prevent further skin break down to R161's achilles area above the heel. On 11/18/11 at 11:30 AM interview with the E1(Medical Director) revealed the doctor should have been notified of R161's increase in edema.	F 157		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment	F 164	F164 1. E17 and E18 received education regarding privacy and covering residents when providing care and pulling curtains completely around the resident. 2. All residents have the potential to be affected by this practice. Ambassador Rounds are conducted routinely to identify privacy and dignity issues and if identified, they are addressed immediately. 3. Staff received re-education on privacy and dignity when providing care to residents. Ambassador Rounds form was revised to include observation of privacy issues, including curtains pulled	

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F 164	Continued From page 3 contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, review of the facility's policy and procedure and interview it was determined that the facility failed to provide privacy for 2 (R65 and R55) out of 52 sampled residents while care was being provided. Findings include: The facility's policy and procedure for bedbath stated to keep the resident covered as much as possible. 1. a. On 11/14/11 at 9:48 AM R65 was observed in her room in bed being bathed by E18 (CNA). R65 was not covered and did not have any clothes on. The curtain was pulled to cover the left side of the bed and a 2nd curtain was pulled to cover part of the right side of the bed. E18 failed to pull the curtain around the bottom of the bed. Near the end of the bed was a dresser with a mirror showing the reflection of the care being provided. The blinds on the windows where pulled approximately 1/2 way up the window. b. On 11/15/11 at 9:40 AM R65 was observed again being bathed by E18 (CNA) with the curtains not pulled around the end of the bed. R65 did not have any clothes on and she was not covered. R65's roommate was in the next bed. Near the end of the bed was a dresser with a mirror showing the reflection of the care being provided. The blinds on the windows where pulled approximately 1/2 way up the window. The facility failed to provide privacy for R65	F 164	completely around the bed and the residents covered appropriately. Staff conducting Ambassador Rounds received education on what to observe with privacy and dignity when conducting their Ambassador Rounds. 4. Results of the Ambassador Rounds compliance are addressed through the routine QA/QI process.	

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F 164	Continued From page 4 during her bath. 2. On 11/16/11 at approximately 1:10 PM R55 was observed receiving perineal care by E18 and E17 (CNAs). R55 was observed in her bed without clothing from the waist down. One curtain was pulled around the left side of the bed and the end of the bed. The second curtain on the right side of the bed was not pulled closed and the window blinds were not closed. A staff member knocked on the door and came in while R55 was exposed from her waist down. On 11/16/11 at approximately 1:30 PM review of the observation with E15 (unit manager) who was also present for the observation of the perineal care confirmed the facility failed to provide privacy for R55 during her care. Review of the bathing and lack of privacy for R65 was also reviewed with E15 on 11/18/11.	F 164	F176 1. R135 was assessed for self administration of medication on the same day the observation was made by the surveyor and self administrates her own medications per physicians order. E8 received on the spot education at the time the observation was made by the surveyor. 2. Residents who request to administer some or all of their medications have the potential to be affected by this practice. An initial audit was conducted on all alert and oriented residents to determine if they have a desire to self administer some or all of their medications. Those residents expressing a desire to self administer medications are assessed for their ability to self administer some or all of their medications. During the admission process, all new residents and/or responsible party are	
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined that the facility failed to assess one (R135) resident for self administration of medications. Findings include: During medication pass observation on 11/16/11	F 176		

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F 176	Continued From page 5 at approximately 11:15 AM, E8 (Licensed Practical Nurse) left medication a cup containing two, Percocet 5/325 mg. (narcotic and controlled substance medication) and Reglan (medication to treat indigestion) 10 mg. on the bedside table of R135 without observing R135 taking her medication and proceeded to leave the resident's room. E8 informed the surveyor that R135 self administered her own medication, thus, no observation was required. Review of facility's policy and procedure titled "Policy 5.6 self-administration of medications" indicated the following: 1. The resident's physician determines the ability of the resident to self-administer medications and writes an order to that affect on the physician's order sheet. 2. The facility's interdisciplinary team is part of the determination of the resident's ability to self-administer medications safely. Record review lacked evidence that R135 was assessed to self administration of medication. In addition, the facility failed to ensure that the above medication was accurately administered by failing to observe the actual administration of medication to R135. An interview with E3 (Director of Nursing) on 11/22/11 at approximately 11:05 AM confirmed that R135 was not assessed for self administration of medication when the above medication observation was conducted on 11/16/11.	F 176	asked if they desire to self administration of medications. The Unit Manager or designee then assesses the resident's competency to self administer medication by completing a self administration assessment form. The attending physician is notified if the resident chooses to self administer medications and meets the criteria to self administer medications. 3. The policy for self administration was reviewed. No changes were necessary at this time. Re-education was provided to licensed nursing staff and the Admissions Director on the policy and procedure for self administration of medications. 4. Routine monitoring of alert and oriented/competent resident's requesting self administration of medications are discussed at the morning meeting. Results are aggregated and results are reported at the monthly QA/QI committee meeting.	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY	F 241		

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F 241	Continued From page 6 The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to promote care for one resident (R219) in a manner that maintained or enhanced her dignity. Findings include: On 11/15/11 from approximately 9 AM to 9:45 AM, R219 was observed in a wheelchair in front of the Station II Nurse's Station with a large area of wetness in front of her pants in addition to an odor of urine. Facility staff members E3 (Director of Nursing), E5 (Unit Manager) and E9 (Licensed Practical Nurse) were observed walking by R219 during this period of time. At 9:45 AM, E5 was informed of the above observation made by surveyor and immediately, R219 taken to her for incontinence care.	F 241	F241 1. R219 is not currently in the facility. 2. All residents have the potential to be affected by this practice. Ambassador Rounds are conducted routinely to identify privacy and dignity issues and are addressed immediately, if applicable. 3. Education was provided to nursing staff regarding dignity issues, including prompt changing of residents when incontinent care is needed. 4. Results of the Ambassador Rounds compliance are addressed through the routine QI/QA process.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.	F 279	F279 1. R182 no longer residents in the facility. 2. New admissions within the past 30 days and any residents identified with a 5% or greater weight variance within the past 30 days were reviewed by the Dietitian and the care plan was revised as appropriate.	

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F 279	Continued From page 7 The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one (R153) out of 52 sampled residents the facility failed to develop a care plan based on an identified care need. Findings include: 1. Cross refer F325 R153 was admitted to the facility on 9/9/11 with a weight of 197 pounds (#). The resident was identified as having edema. On 9/26/11 the resident had a 12# weight loss to 182# and the physician ordered a nutritional supplement of 2 cal 4 ounces twice a day. On 10/4/11 the resident had lost 4 more pounds. The facility failed to develop a care plan to address the resident's weight loss including status of edema, use of nutritional supplements, nutritional risk and poor oral intake.	F 279	3. Education was provided to licensed nursing staff, dietitian and the IDT on developing a care plan for residents at risk for weight variances. 4. Residents identified with a weight variance will be reviewed weekly by the Dietitian and/or designee and will be discussed at the bimonthly "At Risk Meeting." Additionally, these residents will be reviewed at the bimonthly Medical Director's meeting. New admissions are discussed at the routine morning meeting to identify residents at risk for weight variances and to ensure a plan of care is in place. Results are discussed at the monthly QA/QI Committee meeting.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged	F 280	F280 1. R161 no longer utilizes a foot cradle. 2. An audit was conducted on all residents to identify residents with wounds, pressure ulcers or at risk for	

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F 280	Continued From page 8 incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview it was determined that the facility failed to review and revise the care plan for one (R161) out of 52 sampled residents. Findings include: Cross refer F309, example #2 Review of R161's clinical record revealed on 9/14/11 R161 acquired an abrasion to the top of his right foot. On 9/26/11 the physician wrote an order for a foot cradle to his bed. Review R161's care plan revealed the facility failed to review and revise R161's care plan to include the foot cradle to the bed.	F 280	pressure ulcers to ensure current interventions provided were care planned accordingly. Discrepancies were addressed, as appropriate. 3. Braden Scale policy and procedure was revised to include weekly assessments for new admissions and newly developed pressure ulcers. Resident's with pressure ulcers, new admissions and re-admissions are discussed at the routine morning meeting to identify if the resident has wounds, pressure ulcers or at risk for pressure ulcers to ensure interventions are in place and care planned accordingly. Education was provided to licensed nursing staff, Wound Care Nurse and the interdisciplinary care plan team on documenting current interventions on the care plan for residents with pressure ulcers and on the revised Braden Scale Policy and Procedure.	

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F 280	Continued From page 9 On 11/18/11 at 1:30 PM interview with E15 (unit manager) confirmed the facility failed to revise R161's care plan to include the foot cradle.	F 280	4. An audit/report is completed on residents with wounds and pressure ulcers by WCN or designee and is reported to the regional clinical nurse weekly, at the bi-monthly Medical Director meeting, bi-monthly "At Risk" meeting and QA/QI meeting monthly.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview it was determined that the facility failed to provide the necessary care and services for two (R78 and R161) out of 52 sampled residents. R78 failed to have her bowel activity monitored and the physician's orders implemented for constipation. The facility failed to follow the physician order for a bed cradle for R161. Findings include: 1. R78 was admitted to the facility on 8/13/11 with diagnoses including hypertension, diabetes mellitus type II, cerebral vascular accident (CVA), depression, chronic pain, and anemia. R78's 60 day PPS MDS (Minimum Data Set) assessment dated 10/8/11 revealed resident was cognitively intact for daily decision making and required assistance of one staff member for toileting.	F 309	F309 1. R78's care plan and medications for constipation were reviewed and bowel protocol is being implemented accordingly. R161 no longer utilizes a foot cradle. 2. An initial audit was conducted on all residents to ensure bowel protocol is being initialed appropriately. An audit was conducted on all residents to identify residents with wounds, pressure ulcers or at risk for pressure ulcers to ensure current interventions provided were care planned accordingly. Discrepancies were addressed as appropriate.	

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F 309	Continued From page 10 Review of R78's October 2011 physician order form documented that R78 was on Senna Plus (a laxative to treat constipation) two tablets twice a day for constipation. In addition, R78 was on a bowel protocol as follows: 1. Dulcolax (laxative) 2 tablets by mouth or one suppository per rectum times one for no BM (bowel movement) for three days. If not effective, give MOM (milk of magnesia, a laxative). 2. Give MOM 30 ml. (milliliters) by mouth by mouth or gastrostomy tube if Ducolax not effective-If MOM not effective administer Fleets enema (saline laxative)-do not give MOM if resident has a history of renal failure, call physician. 3. Fleet enema per rectum times one if MOM not effective. If no results, call physician for further orders. Review of R78's care plan titled "Bowel elimination problem evidenced by constipation related to decreased mobility, side effect of medication (routine and as needed narcotics), and CVA included a goal that R78 will have a regular bowel elimination pattern as evidenced by soft/formed BM at least once every three days. Approaches included: - Monitor BM status-notify nurse of signs or symptoms of fecal impaction: fever, acute abdomen pain or cramping, nausea, vomiting, and thin watery discharge from rectum. - Administer/monitor effectiveness and side effects of medication used for bowel elimination (Senna Plus). Review of R78's BM activity documented on the	F 309	3. Bowel protocol was reviewed and revised by the Medical Director and DON. BM reports are reviewed daily by the Unit Manager's/Supervisors and bowel protocol is implemented accordingly. Education was provided to licensed nurses on the revised bowel protocol. Education was provided to licensed nurses and CNA's on ensuring current interventions for residents with wounds, pressure ulcers and at risk for pressure ulcers are implemented according to physician's orders and care plan. 4. Care Tracker BM reports are aggregrated and compared with MAR by the QA/QI nurse to ensure bowel protocol is being followed; monthly X 3 months and reported at the monthly QA/QI meeting. A random audit is conducted by the QA/QI nurse on all residents with wounds,	

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F 309	Continued From page 11 October 2011 "Bowel and Bladder Chart Detail Report" revealed that from 10/20/11 (11-7 shift) to 10/26/11 (7-3 shift), 17 shifts and six days there was no BM noted R78's October 2011 Medication Administration Record revealed that R78 was administered two Ducolax tablets on 10/24/11 (7-3 shift), however, this was not effective and R78 did not have a BM. Although R78 was care planned for constipation and had a prescribed bowel protocol as noted above, the facility failed to ensure that these interventions were completed. An interview with E5 (Unit Manager) on 11/22/11 at approximately 11 AM confirmed that the facility failed to initiate the bowel protocol after no BM for three days. In addition, the facility failed to administer the MOM when R78 failed to have a BM after the Ducolax. Nurse's Note dated 10/25/11 timed 3 PM documented that R78 was having loose stools. Although R78 had a possible sign of fecal impaction, as noted on the care plan, record review lacked evidence that the facility completed a comprehensive bowel assessment including bowel sounds. 2. R161 was admitted to the facility with diagnoses that included hypertension, polyneuropathy diabetic, old history of polio, amputation right great toe, cerebral accident, and peripheral vascular disease. On 9/4/11 R161 acquired an abrasion to the top of his left foot. On 9/26/11 the physician ordered a cradle for his bed to prevent the covers/sheets from touching the top of his feet.	F 309	pressure ulcers and at risk for pressure ulcers to ensure interventions are implemented as ordered monthly X 3 months and reported at the QA/QI meeting.	

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F 309	Continued From page 12 On 11/15/11 and 11/1611 during the day shift R161 was observed by two surveyors in bed without the foot cradle in place. On 11/17/11at 9:45 AM an interview with E15 (unit manager) confirmed R161 did not have the foot cradle over his bed on the two aforementioned days.	F 309		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on record review, review of the facility's policy and procedures, and interview it was determined that the facility failed to provide treatment and or accurate assessment for 2 (R228 and R89) out of 52 sampled residents to restore as much bladder function as possible. Findings include: The facility's policy and procedures for urinary and Bowel Incontinence-Evaluation and Management stated: -Upon competition (sic) of the Initial Evaluation for Bowel and Bladder, should the bowel or bladder	F 315	F315 1. A voiding diary was re-initiated on R228 and a toileting program was implemented accordingly. R228's care plan was revised to reflect current toileting status. R89 no longer residents in the facility. 2. An initial audit was conducted on all residents to re-access completion of voiding diaries and implementation of toileting programs. Revisions to toileting programs were implemented as appropriate. 3. Urinary and Bowel Incontinence Policy and Procedure was reviewed and revised.	

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F 315	Continued From page 13 history indicate anything other than continent, a three day, 24 hour, voiding and elimination diary will be implemented. -Subsequent to the competition (sic) of the three day diary, an analysis of the data collected will be completed using the 3 day bowel and bladder evaluation tool. Trends will be reviewed to determine the appropriateness of a toileting program for bowel or bladder or both. -Upon evaluation of the data collection from the 3 day elimination diary, an individualized toileting program will be implemented, if appropriate. 1. R228 was sent from her home to the hospital and was admitted to the facility on 6/23/11. R228 had diagnoses that included bronchopneumonia organism unspecified, alzheimers disease, malnutrition, moderate anxiety disorder, depressive disorder, falls, failure to thrive, anxiety, dysphagia, aspiration pneumonia. Review of R228's admission MDS (Minimum Data Set) dated 6/30/11 documented she was not on a toileting program for bladder training however, she was frequently incontinent with 7 or more episodes of incontinence with at least one episode of continence for voiding. R228's BIMS score was documented at 13 indicating she was cognitively intact. R228's quarterly MDS dated 11/10/11 documented that she was on a toileting program. R228 was assessed for no changes in her urinary continence. Review of the 3 day diary dated 9/9/11, 9/10/11 and 9/11/11 revealed the facility was to assess	F 315	Licensed nurses received education on the revised Urinary and Bowel Incontinence Policy and procedure. New admissions and re-admissions are reviewed at the routine morning meeting to identify residents needing voiding diaries initiated. 4. Audit on residents on toileting programs is conducted by the QA/QI nurse or designee monthly X 3 months and reported at the monthly QA/QI meeting.	

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F 315	Continued From page 14 and document hourly whether the resident was continent, incontinent or dry with the amount voided. On 9/9/11 the voiding dairy documented at 7AM, 9AM, 11AM, 1PM and 2PM a zero with a line through it as the continence assessment. Review of the "CNA worksheet voiding and defecation dairy x 3 days" failed to have documentation to indicate the meaning of/or the use of the zero with the line through it as an assessment. The voiding diary documented R228 was assessed as being incontinent of bladder at 7AM on 2 of the three days, at 10AM on 2 of the 3 days, and 12 noon on 2 of three days. R228's urinary continence documented that R228 was continent and urinated successfully on toilet/bedpan for two of three days at 3PM, 5PM, 7PM, 8PM, 10PM, 11PM 12 midnight, 2AM, 3AM, 5AM and 6AM. On 9/13/11 the physician wrote an order for incontinent care with toileting program for R228. Review of R228's care plan for Incontinent with Toileting Program stated as an approach to "Proivde the following level of self-performance/support for toileting assistance: See schedule". Review of R228's Voiding program/schedule revealed she was to be toileted at 8 AM, 2 PM and 9:00 PM. Review of R228's toileting program on 11/17/11 at approximately 2:45 PM with E15 (unit manager) confirmed R228's 3 day diary was not done correctly in order to capture R228's voiding	F 315		

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F 315	Continued From page 15 patterns. E15 continued to state there should not have been any zeros with a line through it documented as an assessment on the 3 day diary. E15 stated she was going to start a new 3 day diary for R228. Review of the CNA voiding and defecation diary worksheet indicated an assessment was to be done every hour for the 3 day diary. An interview on 11/17/11 at approximately 2:50 PM with E16 (CNA) revealed she only checked/assessed residents every other hour for a 3 day diary she did not check/assess the resident every hour. 2. R89 had a fall at home, was transferred to the hospital then admitted to the facility on 8/5/11 with diagnoses that included right hip trochanter nailing post hip fracture, anemia, coronary artery disease, hypertension and diabetes mellitus, and pacemaker placement. Review of the facility's initial assessment for bowel and bladder training for R89 dated 8/5/11 indicated the facility was to initiate a 3 day voiding diary for R89. There was no 3 day voiding diary found in the chart. Review of R89's MDS dated 8/12/11 and 10/30/11 documented R89 was not on a toileting program. The 8/12/11 admission MDS documented she was frequently incontinent with 7 or more episodes of incontinence with at least one episode of continence for voiding. The 10/30/11 MDS documented she was always incontinent of urine. Review of R89's care plan dated 8/17/11 for Urinary Incontinence documented Resident has a	F 315		

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F 315	Continued From page 16 potential for complications associated with urinary incontinence Resident is not a candidate for B&B retraining as evidence by (no areas checked or written in) related to: diagnoses coronary artery disease, diabetes mellitus and after hip surgery and frequently incontinent. Review of R89's nurses notes for August 2011 documented on several days that R89 yelled out she wanted to go to the bathroom even after she was toileted. Review of the chart with E15 (unit manager) at 12:15 PM on 11/16/11 confirmed the facility failed to initiate a 3 day diary to assess R89's bladder and bowel continence. Therefore, they also failed to provide a individualized toileting program to restore as much bladder function as possible for R89. R89 was discharged back to the community on 11/21/11.	F 315		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.	F 325	F325 1. R153 no longer resides in the facility 2. An initial audit was conducted by the Dietitian on resident's receiving nutritional supplements to ensure residents consistency receiving the supplement. Issues identified were addressed immediately.	

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F 325	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to ensure one (R153) out of 52 sampled residents maintained acceptable parameters of nutrition in the area of weight, meal consumption and supplement consumption. Findings include: R153 was admitted on 9/9/11 with a new suprapubic catheter and diagnoses which included cardiovascular disease, hypertension and chronic renal insufficiency disease. The resident was on a regular diet for his entire stay at the facility. The resident's admission weight was 197# (pounds). The physician's history and physical dated 9/9/11 indicated bilateral leg swelling and pedal edema. E13 (Registered Dietitian/RD) assessed R153 on 9/12/11 as at risk for malnutrition and revealed the resident had declined large portion meals. On 9/26/11 R153's weight was 182# indicating a 12# weight loss or 6% of body weight in less than one month. E13 documented the edema in the legs was improving but still visible and TED hose were still in use and meal consumption was averaging 47%. E13 ordered a nutritional supplement of 2cal 4 ounces (oz) twice a day. The physician's order dated 9/26/11 read 2 cal supplement 4 oz bid (twice a day) with med pass and record # of mls (milliliters) taken. On 10/4/11 R153 weighed 177.6# indicating a 16# or 8% weight loss in approximately one	F 325	3. Education was provided to licensed nursing staff, Dietitian and the interdisciplinary care plan team on developing an appropriate care plan for resident's at risk for weight variance. New admissions within the past 30 days and residents identified with 5% or greater weight variances within the past 30 days were reviewed by the Dietitian and the care plan was revised as appropriate. 4. Residents identified with a weight variance will be reviewed weekly by the Dietitian and/or designee and will be discussed at the bimonthly "At Risk Meeting." Additionally, these residents will be reviewed at the bimonthly Medical Director's meeting.	

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F 325	Continued From page 18 month and E13 noted meal intake was down to 38%. Review of the nutritional supplement documentation revealed that between 9/29/11 and 10/10/11 12 out of 28 opportunities were blank indicating the resident did not receive the supplement. No other nutritional approaches were documented in the clinical record. R153 was discharged home on 10/10/11. An interview on 11/18/11 at about 3 PM with two nurses (E11 and E12) who cared for R153 on both day and evening shifts revealed that the resident did have edema, did not eat much of the facility's food and just wanted to get back home. They further revealed that the resident did not like the supplement and would not always drink it. It was also stated that the family brought food in from home that was not included in the meal intake documentation. An interview on 11/22/11 at 10 AM with E13 RD revealed the resident was admitted with edema and post IV fluids at the hospital. E13 started the supplement when the first weight loss was noted but felt it was mostly fluid weight that was lost. E13 confirmed there was missing supplement documentation and that a care plan addressing the weight loss, edema changes and nutritional approaches was not initiated.	F 325	New admissions are discussed at the routine morning meeting to identify residents at risk for weigh variances and to ensure a plan of care is in place. Results are discussed at the monthly QA/QI Committee meeting. A monthly audit is conducted on residents receiving supplements by the Dietitian or designee to ensure supplements are given as ordered, monthly X 3 months and reported at the monthly QA/QI meeting.	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including	F 329	F329 1. R78 is receiving anti-hypertensive medications per orders.	

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F 329	Continued From page 19 duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R78) out of 52 sampled residents, the facility failed to ensure medications were adequately monitored. Findings include: R78 was originally admitted to the facility on 8/13/11 with diagnoses including hypertension, diabetes mellitus type II, and history of cerebral vascular accident. Review of the November 2011 monthly physician's order sheet documented for both of the medications to treat hypertension, Norvasc 5 mg. (milligram) one tablet by mouth twice a day and Lisinopril 20 mg.	F 329	2. An initial audit was conducted by the pharmacist on all residents receiving anti-hypertensive medication to ensure BP parameters were being followed. All discrepancies were clarified with the physician accordingly. 3. A process for BP parameters and holding anti-hypertensive medications was reviewed with the Medical Director, pharmacist and DON. Guidelines were developed. Licensed nurses were educated on Guidelines for BP parameters and when to hold anti-hypertensive medication(s). 4. A routine audit is conducted by the pharmacist or designee on all residents receiving anti-hypertensive's to ensure BP parameters are being followed and reported monthly X 3 months at the QA/QI meeting.	

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F 329	Continued From page 20 by mouth once a day, the order indicated to hold medications for systolic blood pressure (the top number of the blood pressure/BP reading) less than 110. Review of the November 2011 Medication Administration Record revealed that R78's BP at 5 PM on 11/6/11 and 11/13/11 were 98/60 and 104/56 respectively, however, R78 was administered the scheduled dose of Norvasc 5 mg. by mouth. An interview with E14 (Licensed Practical Nurse who administered the medication on the above dates) on 11/14/11 at approximately 3:15 PM confirmed that she administered the medication although the systolic blood pressure was less than 110.	F 329		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to	F 441	F441 1. There are no specific residents identified in this deficiency. 2. Both nurses, E7 and E6 involved in the incident were educated on proper hand hygiene. 3. Licensed nurses and CNA's received education on proper hand hygiene. 4. Random observation audits are conducted by the QA/QI nurse or designee to ensure appropriate hand hygiene is being performed monthly X 3 months and reported at the monthly QA/QI meeting.	

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F 441	Continued From page 21 prevent the spread of infection, the facility must isolate the resident.. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy and procedures it was determined that the facility failed to prevent the transmission of disease and infection to residents in the facility. Findings include: 1. The facility's policy and procedures titled "Handwashing/Hand Hygiene" indicated: "5. Employee must wash hands for ten to fifteen seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: a. Before and after direct contact with residents; c. After contact with blood, body fluids, secretion,s mucous membranes, or non intact skin; d. After removing gloves;" During medication pass observation on 11/9/11 at 11:24 AM, E7 (LPN) donned a pair of gloves and	F 441		

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F 441	Continued From page 22 completed a fingerstick blood sugar (FSBS) check by obtaining blood from SSR1 finger. E7 then removed gloves and donned new gloves without hand hygiene and proceeded to obtain blood from another resident, R101 to complete a FSBS at 11:30 AM. E7 then removed gloves and proceeded to donned new gloves without hand hygiene and proceeded to prepare and administer insulin to R101's upper left arm at 11:34 AM. 2. During medication pass observation on 11/14/11 at approximately 8:45 AM, E6 (Licensed Practical Nurse/LPN) donned a pair of gloves to administer medication through R15's PEG (percutaneous endoscopic gastrostomy) tube. After this administration, E6 removed the gloves and donned new pair of gloves without hand hygiene and proceeded to administer eye drops to R15. E6 then removed gloves and donned on a new pair of gloves without hand hygiene and administered nebulizer treatment to R15. An interview with E6 immediately after the above observation confirmed that she failed to complete hand hygiene per the facility's policy. 3. Observation on 11/17/11 at 10:50 AM revealed that when E10 finished a treatment on R143 she washed her hands, turning the faucet with her bare hands. This could result in recontamination of the hands.	F 441		
F 498 SS=D	483.75(f) NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents'	F 498	F498 1. R55 no longer resides in the facility.	

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F 498	Continued From page 23 needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's policy and procedures it was determined that the facility failed to provide proper perineal care for one (R55) out of 52 sampled residents. Findings include: The facilities policy and procedure for "Perineal Care" stated to wash the perineal area wiping from front to back. On 11/16/11 at 1:10 PM R55 was observed receiving perineal care from two CNAs E18 and E17. E17 was observed cleaning R55's rectum and gluteal folds when the resident began urinating. E17 took the wipe she used to clean the gluteal and rectal area and wiped R55's perineal area. E17 wiped from the back to the front instead of the front to the back. On 11/16/11 at approximately 1:30 PM E15 (unit manager) confirmed the observation as she was also present observing the perineal care.	F 498	E17 and E18 received education regarding providing proper pericare/incontinence care to residents. 2. All incontinent residents have the potential to be affected by this practice. 3. CNA's received education/competency on proper peri-care/incontinence care. Peri-care/incontinence care is included in the CNA orientation. 4. Random observations are conducted by the Staff Development Director or designee to ensure proper peri-care/incontinence care is being provided monthly X 3 months and reported at the monthly QA/QI meeting.	

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Atlantic Shores Rehabilitation & Health Center DATE SURVEY COMPLETED: 11/22/11

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced annual survey and complaint visit was conducted at this facility from November 9, 2011 through November 22, 2011. The deficiencies contained in this report are based on observation, interviews, and review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was one hundred and sixty-nine (169). The survey sample totaled fifty-two (52) residents and one (1) sub-sampled resident for observation.	Preparation and/or execution of the Plan of Correction does not constitute admission or agreement of the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law.
3201 3201.1.0 3201.1.2	**Skilled and Intermediate Care Nursing Facilities** **Scope** **Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as**	This plan represents the facilities credible allegation of compliance as of 01/31/12. Cross Refer to the CMS 2567 Survey report date completed 11/22/11. F157, F164, F176, F241, F279, F280, F309, F315, F325, F329, F441 and F498. N. P[illegible] 12/21/11 Administrator

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	evidenced by: Cross refer to the CMS 2567-L survey report completed November 22, 2011, F157, F164, F176, F241, F279, F280, F309, F315, F325, F329, F441 and F498.	